

FEDERAL BUREAU OF INVESTIGATION
 FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 16 1960

=60-033361

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2235

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch</u> | | Length of stay in 1b <u>DAYS</u> | c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>4741 Nebraska</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | |
|---|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle _____ Last <u>Blick</u> | | | 4. DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>60</u> | | |
|---|--|--|---|--|--|

| | | | | | | |
|-----------------|----------------------------|--|----------------------------------|----------------------------------|--|--|
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W.</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-13-74</u> | 9. AGE (last birthday) <u>85</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
|-----------------|----------------------------|--|----------------------------------|----------------------------------|--|--|

| | | | |
|--|---|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u> | 10b. KIND OF BUSINESS OR INDUSTRY _____ | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
|--|---|---|--|

| | | |
|--|--|---|
| 13a. FATHER'S NAME <u>Phil Erhardt</u> | 13b. MOTHER'S MAIDEN NAME <u>Margaret Foster</u> | 14. NAME OF HUSBAND OR WIFE <u>Charles Blick-deceased</u> |
|--|--|---|

| | | |
|---|----------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ | 16. SOCIAL SECURITY NO. <u>?</u> | 17. INFORMANT Address <u>Robt. Koch Record Room Hosp. Koch, Mo</u> |
|---|----------------------------------|--|

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease,</u> DUE TO (b) <u>generalized arteriosclerosis, severe</u> DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH _____ |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

| | | |
|--|---|--|
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____ |
|--|---|--|

| | | | |
|---|--|--|---|
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | 20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____ |
|---|--|--|---|

21. I attended the deceased from 6-9-60 to 7-25-60 and last saw her alive on 7-25-60
 Death occurred at 10:45 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|---|--|------------------------|
| 22a. SIGNATURE (Degree or title) <u>Arcl R. Brown, M.D.</u> | 22b. ADDRESS <u>Robert Koch Hospital, Koch, Mo</u> | 22c. DATE SIGNED _____ |
|---|--|------------------------|

| | | | |
|--|--------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>July 28, 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Concordia Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u> |
|--|--------------------------------|--|---|

| | | |
|--|---|--|
| 24. FUNERAL DIRECTOR ADDRESS <u>BEIDERWIEDEN F. H. 1936 St. Louis Ave.</u> | 25. DATE RECD. BY LOCAL REG. <u>7-26-60</u> | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> |
|--|---|--|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4526

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.